The State's EHB-benchmark Plan's Benefits and Limits

OMB Control Number: 0938-1174
Expiration Date: 06/01/2021

Instructions: All fields on this template that are marked red are required to be completed. To ensure that this Benefits and Limits Summary Template corresponds with the EHB-benchmark plan document, please indicate the page number in which the benefit is covered under Column H if answering "Covered" under Column C (for example, "Covered" in Column C, "pg. 12" in Column H). If there is a quantitative limit on a benefit, then complete the Limit Quantity and Limit Unit fields. If there are no exclusions for a benefit, then leave the Exclusions field blank. Add an explanation in Column H to provide more details on a benefit.

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				pg. 7, 15
Specialist Visit	Yes	Covered	No				pg. 7-8
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				pg. 7
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				pg. 21
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				pg. 21
Hospice Services	Yes	Covered	No				pg. 21-22; Coverage includes inpatient and outpatient hospice care.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No				pg. 27-28; Underlying causes only.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	No	Not Covered	No				
Routine Eye Exam (Adult)	No	Covered	Yes	1	Exam(s) per Year		pg. 16, 31; Included as part of annual physical exam.
Urgent Care Centers or Facilities	Yes	Covered	No				pg. 10, 23
Home Health Care Services	Yes	Covered	No				pg. 16-17
Emergency Room Services	Yes	Covered	No				pg. 10-11, 23
Emergency Transportation/Ambulance	Yes	Covered	No				pg. 11
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				pg. 22
Inpatient Physician and Surgical Services	Yes	Covered	No				pg. 22
Bariatric Surgery	Yes	Covered	Yes	1	Procedure(s) per Lifetime		pg. 70
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	45	Day(s) per Year		pg. 23
Prenatal and Postnatal Care	Yes	Covered	No				pg. 28
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				pg. 28
Mental/Behavioral Health Outpatient Services	Yes	Covered	No				pg. 25-26
Mental/Behavioral Health Inpatient Services	Yes	Covered	No				pg. 25-26
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				pg. 27
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				pg.27
Generic Drugs	Yes	Covered	No				pg. 13, 20-21
Preferred Brand Drugs	Yes	Covered	No				pg. 13, 20-21
Non-Preferred Brand Drugs	Yes	Covered	No				pg. 13, 20-21
Specialty Drugs	Yes	Covered	No				pg. 13, 20-21
Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Year		pg. 18-19; PT/OT/Chiro - combined visits per contract year; 30 ST per contract year; 30 cardiac/pulmonary visits per contract year.
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Year		pg. 18-19; Yearly limits: PT and OT: 30 visits, Speech: 30 visists.

Chiropractic Care	Yes	Covered	Yes	30	Visit(s) per Year		pg. 18-19; Limit combined with OT and PT.
Durable Medical Equipment	Yes	Covered	No				pg. 23-24
Hearing Aids	No	Not Covered	No				
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				pg. 9, 22
Preventive Care/Screening/Immunization	Yes	Covered	No				pg.12
Routine Foot Care	No	Not Covered	No				
Acupuncture	No	Not Covered	No				
Weight Loss Programs	Yes	Covered	No				pg.20
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year		pg. 14, 31; FEDVIP BlueVision
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		FEDVIP BlueVision
Dental Check-Up for Children	Yes	Covered	Yes	2	Visit(s) per Year		MIChild
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Year		pg.18
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Year		pg.18; Combined with chiro.
Well Baby Visits and Care	Yes	Covered	No				pg. 28
Laboratory Outpatient and Professional Services	Yes	Covered	No				pg. 22
X-rays and Diagnostic Imaging	Yes	Covered	No				pg. 22
Basic Dental Care - Child	Yes	Covered	No				MIChild
Orthodontia - Child	No	Not Covered	No				
Major Dental Care - Child	Yes	Covered	No				MIChild
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Not Covered	No				
Transplant	Yes	Covered	No				pg.20
Accidental Dental	No	Not Covered	No				
Dialysis	Yes	Covered	No				pg. 21
Allergy Testing	Yes	Covered	No				pg. 15
Chemotherapy	Yes	Covered	No				pg. 21
Radiation	Yes	Covered	No				pg. 22
Diabetes Education	Yes	Covered	No				pg. 15
Prosthetic Devices	Yes	Covered	No				pg. 25
Infusion Therapy	Yes	Covered	No				pg. 9
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				pg. 30-31; Coverage includes medical care or services to treat dysfuction or TMJS resulting from a medical cause or injury, Office visits for medical evaluation and treatment, X-rays of the temporomandibular joint including contrast studies, but not dental X-rays, Myofunctional therapy and Surgery to the temporomandibular joint, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.
Nutritional Counseling	Yes	Covered	Yes	6	Visit(s) per Year		pg. 16; Dietician Services.
Reconstructive Surgery	Yes	Covered	No				pg. 17-18

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